

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-006843

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUD

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 594

594

FILED FEB 18 1963

VS 300  
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>KANSAS CITY</u>		c. CITY OR TOWN <u>KANSAS CITY</u>	
Length of stay in 1b <u>3 years</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>2839 Troost</u>		d. STREET ADDRESS (If outside, give location) <u>2839 Troost</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <u>Alice Green Morris</u>			
4. DATE OF DEATH Month Day Year <u>JAN 27 1963</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-5-79</u>
9. AGE (last birthday) <u>84</u>		10. IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (City and state or country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
14. NAME OF HUSBAND OR WIFE <u>Walter Morris</u>		Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, never unknown) (If yes, give war or dates of) <u>No</u>		16. SOCIAL SECURITY NO. <u>Millard Shaw, 2839 Troost Ave. KCM</u>	
17. INFORMANT <u>Millard Shaw, 2839 Troost Ave. KCM</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Pulmonary Emboli</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>Arteriosclerosis</u> DUE TO (b) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from: <u>1-25-63</u> to <u>1-27-63</u> and last saw her alive on <u>1-26-63</u> Death occurred at <u>11:05 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Theodore F. Foster, D.O.</u>		22b. ADDRESS <u>6305 Main Street</u>	
22c. DATE SIGNED <u>1-28-63</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
23b. DATE <u>1-28-63</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ashland, Missouri</u>	
23d. LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR <u>Burnett Funeral Home, Ashland Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>1-29-63</u>		26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>	

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

BY AFFIDAVIT OF THEODORE F. FOSTER, M.D. MEDICAL CERTIFICATION

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*John R. Simon*

Licensed Embalmer No.

*4531*

P. O. Address

*Kansas City, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.